The Partnership Plan
Commonwealth of Kentucky

Section 1115 Waiver Renewal Request

I. A Brief History of The Partnership Program Waiver

In December 1995, the Commonwealth of Kentucky was granted approval for an amendment to its Section 1115 Waiver Demonstration Project (No. 11-W-0000-5/4-01). The approved amendment permitted the Commonwealth to attempt a truly innovative approach to establishing managed care in a rural and medically under-served area of the country.

The concept embodied in the Commonwealth's approved amendment was the establishment of health care partnerships. These partnerships were to be coalitions of medical providers in both the public and private sectors who would come together to provide comprehensive medical services through integrated service delivery networks to Medicaid beneficiaries living in a designated region of the Commonwealth. The health care partnerships were to participate in the Medicaid program as comprehensive risk-based entities paid an actuarially sound capitation rate per member per month. The partnerships would serve as sole-source managed care providers in their respective regions and virtually all Medicaid beneficiaries in the region would be assigned to the plan. Each partnership plan would have significant beneficiary representation on its governing board and providers and beneficiaries would decide together how best to manage both health care needs and costs.

The concept was particularly appealing in a state in which there was little commercial managed care and in which the medical community was enthusiastic about attempting such a bold experiment. Initially, two such partnerships were developed and implemented in Region 3 (Louisville and 15 surrounding counties) and Region 5 (Lexington and its' surrounding counties). Combined, the regions served approximately 34% of the Kentucky Medicaid population. Additional partnerships in six other regions were to be developed in the second and third years of the waiver project.

In the first two years of the project, the partnerships in Regions 3 and 5 demonstrated the efficacy of the concept and medical outcomes began to improve even as costs were held somewhat below the actuarially determined upper payment limit. Furthermore, beneficiaries reported increased satisfaction with their medical care. But debates continued to rage about the quality of managed care and providers in many parts of the state resisted aligning with a risk-based managed care product.

In 1999, the Region 5 partnership notified the Department for Medicaid Services (DMS) that it could no longer hold its provider community together, primarily over widespread dissatisfaction with federally mandated reporting requirements, and what they felt were unacceptable profit margins. The Commonwealth used the opportunity to review the

project's scope and conceptual base in light of provider concerns and the increased likelihood that no further regional partnerships were possible.

Before making a final decision about how best to proceed, the Commonwealth published a Request for Information (RFI) to probe for any interest in the Medicaid business from national managed care organizations, some of which were offering HMO products in limited parts of Kentucky, followed by Request for Proposal (RFP). There were no viable responses. After much discussion and debate, the Commonwealth decided to strengthen its KenPAC program, a primary care case management model, pursuant to new authority in the Balanced Budget Act of 1997, and to seek authority from CMS to continue to operate its one remaining partnership plan.

In 1999, the Commonwealth requested and CMS approved an amendment of its waiver program. Since July 2000, the Commonwealth has been operating its partnership plan, known as Passport, only in Region 3 (Louisville and its' surrounding counties). It is this project that the Commonwealth now seeks to extend for an additional 3 years.

II. Program Successes

Despite some of the difficulties in forming and maintaining partnership plans throughout the Commonwealth, the Passport Plan operating in Region 3 has demonstrated some remarkable successes. Perhaps most important is the widespread participation of the provider community in Louisville and the surrounding counties included in the Passport Plan. Currently, Passport members have the freedom to choose among 3095 physicians, 31 hospitals, and 295 providers of ancillary services. The Passport Network includes 895 primary care providers in over 220 locations and 1874 specialty providers located throughout the Region. All hospitals in the region participate in the Passport Plan. All providers participating in the Passport network must undergo an extensive credentialing process and the providers meet regularly to identify and remove barriers to care as they are identified.

A number of studies and surveys have been completed on the Passport Plan. Studies performed by the External Quality Review Organization (EQRO) document excellent progress in meeting national guidelines for EPDST screenings and treatment as well as improved health outcomes as a result of a sophisticated case management system. The Passport Plan has initiated a clinical quality improvement study to increase immunization rates for children. There has been an almost 200% increase in the EPSDT screening rates in Region 3. EPSDT screenings have risen from 17% to almost 50% as a result of targeted interventions. In addition, the rate of well-child visits in the first 15 months of life has increased almost 65%.

In the most recent survey of Health Outcomes and Member Satisfaction (Attachment VIII), the plan demonstrated not only significant gains in improving health outcomes but also its increasing maturity as a plan. The Health Outcomes were assessed through the National Committee for Quality Assurance's (NCQA) Health Plan Employer Data and

Information Set (HEDIS) 2001 tool and member satisfaction was assessed through the NCQA's tool known as Consumer's Assessment of Health Plan Survey (CAHPS).

In the Winter of 2000, Passport released its first fully audited HEDIS results for calendar year 1999, in which Passport exceeded the Medicaid mean as reported by NCQA in 80 percent of the measures targeted by the Plan for interventions. This achievement was far greater than that expected of a Plan with only two full years of operation at completion of the measurement year. At year-end 2000, Passport had exceeded the Medicaid mean in 97 percent of the measures.

Passport operates a special maternity program called Mommy and me, designed to improve perinatal outcomes including prenatal care in the first trimester, check-ups after delivery and to reduce incidences of low birth weight and infant mortality. This program has become a national model for increasing access to home visiting services and, thus, for improving the health of pregnant mothers and their babies.

Passport has developed clinical guidelines for pediatric and adult preventive screenings, diabetes and cardiac care. Passport recently implemented a care management program for members with diabetes and has hired a disease case manager for this program.

The Passport Plan has also developed a system of administrative services and performance measures that rival those of a commercial HMO including those for member and provider complaint resolution, appeals, out of plan utilization, call abandonment rates and the average speed in which phone calls are answered. The high rate of member satisfaction attests to the success of these efforts.

Passport staff has been active in addressing issues around cultural sensitivity within their membership including attending classes in sign language and Spanish. The outreach department has become an integral part of the communities in Region 3 promoting health and wellness and educating their communities about access to Medicaid and KCHIP programs and services. (See Attachments VI and VII)

All of these efforts contribute to the health and well being of the Medicaid beneficiaries living in Region 3 in ways that are difficult to achieve at the state level and are often not found in a commercial HMO operation. The regional plan concept with its emphasis on provider cooperation and oversight, has demonstrated a unique ability to influence provider behavior and regional practice patterns.

III. Program Design Modifications

The Commonwealth does not intend to make any major modifications to the program design as it was approved by CMS in 2000. (Attachments I, II, and III provide a summary of geographic coverage, eligibility groups enrolled and benefits covered). The Commonwealth will seek a new budget neutrality agreement (See Section V) using a

historically accurate trend rate. In addition, the Commonwealth and the Passport Plan would like to reserve the option to implement modest co-payments for prescription drugs and the non-emergency use of emergency rooms. If and when the Commonwealth and Passport get ready to implement these co-payments, the Commonwealth will request a formal waiver amendment with the specifics of the proposed co-payment schedule.

At this time, the Commonwealth does not anticipate being able to contract with partnership plans in any regions of the state beyond Region 3.

The Commonwealth will be updating and revising its proposed contract with the Passport Health Plan to accommodate changes to Medicaid contract requirements as contained in the Balanced Budget Act of 1997. A revised contract will be forwarded to CMS for review within a month of the submittal of this waiver extension request.

At the point at which CMS is ready to discuss the Terms and Conditions of its approval of the extension, the Commonwealth would like to discuss some slight modifications in the format and timeframes for certain reports that will be submitted to CMS to assist in its monitoring of the program. Most of these changes are as a result of Passport's maturation as a plan and the fact that it is able to report in HEIDIS format. (Attachment IV).

IV. Waivers Requested

In order for the Commonwealth of Kentucky to implement the amended Demonstration Project described in this waiver request, it must be granted waivers from certain statutory and regulatory requirements of the Medicaid program. The specific waivers requested are listed below.

1. Comparability

Section 1902(a)(10)(B) and 42 C.F.R. §§ 440.230-250 require that the amount, duration, and scope of services be equally available to all recipients within an eligibility category and be equally available to all categorically eligible recipients and medically needy recipients. Kentucky's demonstration project will, in some cases, provide for services to be delivered in different delivery structures than those delivery structures offered to the non-demonstration Medicaid population. Therefore, the Department requests a waiver of these sections.

2. Eligibility Procedures

Section 1902(e)(2) and 42 C.F.R. § 435.212 provide that a recipient who is enrolled in a federally qualified HMO and who becomes eligible for Medicaid may be considered eligible for no more than six months from the date of enrollment and, except for family planning services, only for services furnished by the HMO.

Kentucky requests a waiver of these sections in order to guarantee managed care program members, regardless of the type of health plan, will be eligible (absent fraud), for all Medicaid benefits for a six month period from the date of their initial eligibility. This six month guaranteed period will be granted only once per eligible.

3. Retroactive Coverage

Section 1902(a)(34) and 42 C.F.R. § 435.9 14 requires states to retroactively provide medical assistance for three months prior to the date the application for such assistance is made. The Department requests a waiver to eliminate retroactive eligibility and the requirement for prior quarter medical coverage.

4. Freedom of Choice

Section 1902(a)(23) and 42 C.F.R. § 431.51 provide that any individual eligible for medical assistance may obtain such assistance from any institution, agency, community, pharmacy, or person qualified to perform the service of services. The demonstration, as proposed, will restrict each participant to a single health care partnership. Further, enrollees will not be choosing among competing plans. They will, however, have the freedom to choose among the 3000+ physicians and 21 hospitals that comprise the Passport network. Therefore, the Commonwealth seeks a waiver of the above referenced provisions of statute and regulation.

The Department further seeks appropriate waiver authority to similarly restrict dual Medicare/Medicaid eligible beneficiaries to a single health care partnership.

5. Statewideness

Section 1902(a)(1) requires a state to provide that state plans for medical assistance be in effect in all political subdivisions of the State. The demonstration will be in effect in only one (1) geographical area of the State.

6. Payment of FQHCs and Rural Health Clinics

The Commonwealth reiterates its request of September 13, 2001, for a waiver of Sections 1902(aa) and 1902)a)(15) of the Social Security Act that requires states to make supplemental payments to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) that subcontract with managed care entities. These waivers would restore the Partnership Program to its original terms and conditions and replace the waivers that were negated by the passage of the Benefits Improvement and Protection Act (BIPA) of 2000.

7. Other Waivers

Finally, the Department requests that CMS grant any other waiver that CMS deems to be required in order to implement the managed care program described in this document.

V. Budget Neutrality

The Department's analysis of Budget Neutrality for the four (4) completed years of the waiver shows that the state has successfully met the Budget Neutrality requirements for this time period. Total expenditures for the first four years of the waiver were $77,603,051 below the projected "without waiver" costs that were calculated based upon a 6.2% annual growth factor.

The costs of providing services under the Waiver for four (4) fully completed years were $1,624,042,447. These costs were derived from date of service payment data that included capitation payments, incentive payments and fee-for-service payments attributable to recipients who were eligible for the waiver but not enrolled. A drug rebate was applied to the fee-for-service drug costs.

The costs of providing the same services without the Waiver for the same time period were estimated to be $1,701,645,498. These costs were calculated using a projected PMPM for each Waiver year. The projected PMPM was developed in accordance with Attachment D of the Terms and Conditions of the Waiver.

The analysis of Budget Neutrality for Waiver Year 05 will be measured using the same method and will be forwarded to CMS upon within six (6) months after completion of the waiver period.

The Department requests a budget neutrality trend factor of 7.43% for the waiver renewal period, November 2002 through October 2005. This increased trend rate reflects the changes that have taken place in the health care environment since the mid-1990's which have resulted in increased expenditures in the Medicaid program.

The state's request is based on its analysis of the historical growth of fee-for-service expenditures in Managed Care Region 6 which is comprised of counties located in the Cincinnati, Ohio Metropolitan Statistical Area (MSA). This region borders Region 3 and is demographically comparable. Region 3 includes counties located in the Louisville MSA. Other areas of the state are predominantly rural and any comparisons made to these regions would not be reflective of the growth experienced in the more urban areas of the state.

Historical fee-for-service data from the implementation of the Waiver (November 1997) through March 2001 was used to calculate a fee-for-service per member per month

(PMPM) trend rate. Data from April 2001 through current was not used due to the unknown impact of incurred but not reported (IBNR) claims. Only those claims for services covered under the Waiver attributable to recipients who meet the criteria to be eligible under the Waiver were included in the calculation.

The detailed spreadsheets required by CMS are included as Attachment V. In addition, the Commonwealth has created a CD that contains all of the raw data used in developing the report on budget neutrality and the proposed trend rate. A copy of that CD will be sent to CMS under separate cover.

VI. Assurances of Compliance with Current Waiver Terms and Conditions

The Commonwealth is in compliance with all the Terms and Conditions of its Section 1115 Waiver as amended with CMS consent in 2000.

VII. Public Notice

Pursuant to 42 CFR 447.205, notice of the Commonwealth's intent to seek an extension of its Section 1115 waiver was published in all newspapers with the widest circulation in each city with a population of 50,000 or more. Public notice was published in November of 2001.

VIII. Attachments

I. Map of Counties Included in Region 3
II. Chart of the Eligibility Groups in Partnership
III. Chart of the Benefits Offered in Partnership
IV. Requested Reporting Modifications
V. Budget Neutrality Spread Sheets
VI. Passport Report to the Community 1999
VII. Passport Report to the Community 2000
VIII. Passport 2000 Health Outcomes and Member Satisfaction Surveys